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James Kegley

Bringing Up Baltimore

One city's approach to strengthening its most vulnerable families

The Pew Charitable Trusts

Susan K. Urahn, *executive vice president*

Alexis Schuler, *senior director*

Team members

Karen Kavanaugh, *director*

Mimi Alejo-Sandoval, *senior associate*

Danita Moses, *administrative assistant*

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Contact: Jennifer Stapleton, communications officer

Email: jstapleton@pewtrusts.org

Project website: pewtrusts.org/homevisiting

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Contents

1	Overview
2	Step 1: Get leadership buy-in
3	Step 2: Conduct a needs assessment
4	Step 3: Select evidence-based programs
6	Step 4: Implement evidence-based programs and create a unified system
7	Step 5: Provide staff with training and technical assistance
8	Step 6: Establish a central triage and referral process
9	Step 7: Establish a monitoring and reporting system
11	Step 8: Monitor implementation and outcomes
12	Baltimore's Home Visiting Transition at a Glance
14	Baltimore Transition Milestones
15	Endnotes



James Kegley

Overview

In 2008, the city of Baltimore undertook a first-of-its-kind effort. First, it sought to transition its home visiting programs into using only evidence-based program models. Second, the city worked to build a unified system of services. And finally, it moved to establish procedures to measure the results. Like the many policymakers across the country considering similar shifts, leaders in Baltimore were searching for better outcomes for children and families and continued support from public and private funders who, in recent years, had increasingly sought greater effectiveness and accountability.

To understand what worked and what didn't in Baltimore's transition to evidence-based home visiting and what factors influenced city leaders' strategies and choices, The Pew Charitable Trusts commissioned Carson Research Consulting Inc. to conduct interviews with stakeholders: agency personnel, providers, and families. The city's experience is instructive as more states and municipalities attempt similar changes to better support young families and provide taxpayers with the best return on their investment.

Baltimore's transition to evidence-based home visiting began with a critical decision-making process. City policymakers, faced with the fourth-highest infant mortality rate among U.S. cities of comparable size in 2009, conducted a needs assessment to document problems and identify areas for improvement. They also undertook a comprehensive literature review to find potential solutions. They determined that high-quality home visiting was an important, high-impact component of an improved early childhood system of care.

Using the existing research base, leaders found that properly implemented home visiting could effectively improve birth outcomes, provide family support, and enhance the health of young children as part of a larger comprehensive plan. As a result of this process, policymakers agreed that home visiting should continue in the city—not as it had, as disparate programs with no central strategy, but rather as an aligned system implementing proven practices.

City officials designed a new home visiting system that includes two federally approved, rigorously evaluated, evidence-based models—Nurse Family Partnership and Healthy Families America—which they believed could reach those expectant mothers most at risk for low-birth-weight babies, preterm births, infant mortality, and child abuse and neglect. They also developed a central system to identify, engage, and enroll targeted mothers and provide a single point of entry into the home visiting system.

This brief offers an overview of the Baltimore experience and identifies the eight steps that were key to the city's successful transition:

1. Get leadership buy-in.
2. Conduct a needs assessment.
3. Select evidence-based programs.
4. Implement evidence-based programs and create a unified system.
5. Provide staff with training and technical assistance.
6. Establish a central triage and referral process.
7. Establish a monitoring and reporting system.
8. Monitor implementation and outcomes.

Support from the highest levels of government is essential to systemwide change, especially when the transition will be challenging for some stakeholders.

Step 1: Get leadership buy-in

Support from the highest levels of government is essential to systemwide change, especially when the transition will be challenging for some stakeholders. At a minimum, in the case of home visiting, support must come from the decision-makers for maternal and child health, education, and child welfare.

In 2009, leaders from Baltimore agencies and nonprofits launched B'more for Healthy Babies (BHB), a public health initiative to reduce poor birth outcomes and promote healthy families. The mayor's office is the official lead for BHB, and day-to-day operations are handled by the Baltimore City Health Department and the nonprofit Family League of Baltimore. The BHB team, in turn, leveraged considerable influence and expertise to develop a comprehensive program for improving policies and services for expectant mothers.

CareFirst BlueCross BlueShield, a nonprofit health care organization serving individuals and groups in Maryland, made an initial commitment of \$3 million to BHB to promote access to medical care and support services for pregnant and new mothers. The grant provided the resources the initiative needed to align major funding streams—federal, state, city, and foundation funds for multiple maternal and child health initiatives including home visiting—toward the common goal of preventing poor birth outcomes and strengthening families.

BHB invested time and dollars in coalition building and strategic planning with city agencies across numerous sectors, including the mayor's office, the Social Services and Parks and Recreation departments, school-based health centers, city birthing hospitals, academic institutions, nonprofits, and community and civic agencies. These stakeholders created action plans for reducing fetal and infant mortality, child fatalities, teen pregnancy, and substance-exposed pregnancies and for increasing family literacy and nutrition, and exercise among pregnant mothers.

To begin developing a comprehensive strategy, BHB staff mapped the factors affecting local birth outcomes before, during, and after pregnancy. First, they looked at the types of care needed at each stage. Next, they identified modifiable factors related to poor birth outcomes, such as smoking, substance abuse, and poor nutrition, as well as underlying causes of poor reproductive health such as poverty, substandard housing, and lack of access to health care. Finally, they explored interventions that could effect change.

In presenting their findings and recommendations to city leaders, BHB staff emphasized the research on home visiting, which systems-change studies show helps build support for a transition to evidence-based

programming. In Baltimore, BHB's recommendations had the backing of administration and agency leaders, including the Health Department commissioner and the mayor. The Department of Social Services is well-integrated into the BHB system as a referral partner, as are the Women, Infants, and Children and the Baltimore Infants and Toddlers programs.

Other leadership support came from the state. A 2012 Maryland law, which was supported by the state's Department of Health and Mental Hygiene, requires that 75 percent of state home visiting funding be used to support evidence-based programs. When changes became political or difficult, such as when some Baltimore home visiting providers resisted the imposition of evidence-based models, the law made these charged decisions easier to enforce and implement. It also aligned with the federal Maternal, Infant, and Early Childhood Home Visiting program (MIECHV) parameters on funding for evidence-based programs.

Step 2: Conduct needs assessment

To get the most from home visiting investments, program goals must be clear. A needs assessment can identify and prioritize the problems a reform effort is trying to address. Those objectives must then be aligned with existing programs, funding, curricula, eligibility criteria, and staffing levels.

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In 2008, Baltimore's infant mortality rate was 13.5 per 1,000 live births—the fourth-highest rate of major U.S. cities and the highest in Maryland. That year, 120 babies younger than 1 year died in the city. In 2009, that increased to 128. In particular, the city was struggling with extremely high rates of infant deaths due to unsafe sleep practices and of preterm and underweight births, both key indicators for infant mortality and other major health and developmental problems.

Home visiting programs had existed for many years in Baltimore, but they lacked coordination; demonstrated little evidence of success; and had varied curricula, standards of care, and goals. The deputy director of one local organization said, "Sometimes you'd hear a program would pop up, but you wouldn't know what the [eligibility] criteria were. And they would be open for a minute, and then they'd close their doors."

In 2009 and 2010, BHB conducted a home visiting needs assessment designed to evaluate the referral system and develop profiles of the nine programs operating in the city. The programs had a combined budget of approximately \$7 million from federal sources, state funds, city general funds, and foundations and other sources. The assessment showed the following:

- Inconsistent curricula. The nine programs used 10 curricula. Only one—DRU/Mondawmin Healthy Families Inc. (DRUM)—was implementing an evidence-based model.
- Inconsistent services and training. Staffing, eligibility, services offered, discharge criteria, and training and service orientation differed significantly across programs.

- Duplication in recruitment. The programs employed multiple methods for recruiting participants but did not share information or maintain a centralized system of triage—intake, evaluation, and referral. This led to much duplication in some areas of the city and no access to services in others.
- Failure to meet community needs. Although approximately 6,000 of the city's 10,000 births were classified during the assessment period as high risk, the nine programs had capacity to serve only 1,722 families; fewer than 1,500 women received ongoing support from a home visiting program in 2009.
- No standardized data-reporting system. The content and level of data collected varied across programs, with multiple databases employing different definitions for indicators and data entry. Although the programs had agreed to have a standard set of benchmarks, no objective mechanism was in place to follow up on data collection or on reporting processes. Several programs did not share data routinely. Improvements were essential in all four areas of the standard data management cycle: collection, processing, analysis, and reporting.
- No demonstrated effectiveness. Given the data problems, it was very difficult to properly monitor and evaluate home visiting programs for effectiveness. Each program claimed to have positive client outcomes, but when service areas were mapped against vital statistics, many critical neighborhood indicators—such as low birth weight, smoking rates, or birth spacing—showed virtually no change.

Step 3: Select evidence-based programs

The U.S. Department of Health and Human Services (HHS) has identified 17 home visiting program models that meet its criteria for being evidence-based.¹ Additionally, many states, including Maryland, have developed their own standards. Mapping those programs' target populations, results (such as improved school readiness or birth outcomes), costs, and implementation requirements against the local context is essential to a successful transition.

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Baltimore developed a team of state and city stakeholders, including agency and academic experts, home visiting providers (front-line and managerial), obstetric and pediatric practitioners, and others to define the criteria for choosing the city's home visiting models. They studied maternal health profiles from vital statistics and other sources and conducted interviews and focus groups with key stakeholders.

In 2010, the team proposed that the city adopt two models—Nurse Family Partnership (NFP) and Healthy Families America (HFA)—based on the Baltimore needs assessment as well as one conducted by the state. The recommendations were adopted, and BHB began using two evidence-based home visiting models that meet criteria established by HHS and have been shown in rigorous research to yield benefits in Baltimore's target outcome areas. NFP was selected to serve low-income, high-risk, first-time mothers who are less than 28 weeks pregnant. HFA was chosen to serve pregnant and newly delivered mothers with more than one child who have

psychosocial risk factors and lower-risk medical conditions. (An enhanced version of HFA, staffed by nurses and being evaluated for its effectiveness, is also in use with pregnant women who already have children and who are at high medical risk.)

In a randomized, controlled trial among black, Hispanic, and unmarried mothers in New York, participation in HFA reduced the risk of low birth weight by about 50 percent.² An earlier study in Alaska found that after participating in HFA, mothers had higher levels of confidence in their parenting skills and families created better home environments for learning.³

NFP is one of the most thoroughly evaluated home visiting programs and has shown consistent and sustained benefits. Multiple randomized, controlled trial studies show benefits for child health, school readiness, and maternal life course, among other outcomes.⁴ Moreover, follow-up studies show these positive effects endure for the children whose mothers participated in NFP. One such analysis found that, compared with their peers whose mothers did not receive NFP services, 19-year-old daughters of participating mothers had fewer arrests and convictions, and the children of poor, unmarried NFP moms had fewer children and used less Medicaid.⁵

In choosing the combination of these two models, the stakeholder team considered the challenges facing the target populations that add to their risk profiles for poor birth outcomes, including high rates of maternal substance abuse, mental illness, and diabetes and hypertension, and family transience and homelessness. NFP was a good fit because it uses nurses to deliver services to mothers at risk for poor birth outcomes. However, the program accepts only first-time mothers before their 28th week of pregnancy. HFA, with its less strict eligibility, could expand the reach of home visiting services to high-risk moms who do not meet NFP's criteria.

BHB also took other local factors into account. First, a well-respected HFA program, DRUM, had been operating in the city since 1999, and its credibility in the home visiting community could help promote buy-in among providers and families for the switch to the HFA models. Second, NFP has a very rigorous implementation plan, while HFA provides a great deal of flexibility, allowing programs to tailor the structure of their activities and services to the diverse needs of the communities they serve. Third, selecting both models enabled the city to serve women with different levels of risk. Finally, choosing NFP, the only evidence-based home visiting program that uses nurses, supported a greater focus on the medical needs of Baltimore's highest-risk mothers and made sense from a workforce perspective because many of the city's home visitors are unionized nurses.

Low-income women on Medicaid make up the majority of the target population, but in light of Baltimore's limited resources, a woman's level of risk and place of residence are also taken into account in prioritizing referrals. HFA is implemented through five community-based organizations across the city, each with a designated geographic "catchment" area. NFP is open to women living anywhere in the city, provided they meet the program's strict eligibility criteria. (During 2014, HFA catchment areas were expanded to provide equitable distribution of services citywide.)

All evidence-based home visiting services administered by the city Health Department and the Family League of Baltimore provide participating mothers with information on family planning, mental health care, literacy, safe sleep practices (such as always putting infants to sleep on their backs), smoking cessation, effects of secondhand smoke exposure, and breastfeeding.

In 2015, Baltimore won a large Head Start grant that incorporated Early Head Start (EHS) to serve mothers with a lower risk level through home visiting and center-based services. EHS has shown improved birth outcomes and school readiness for vulnerable children.

Step 4: Implement evidence-based programs and create a unified system

Once program models are selected, administrators must decide how they will be implemented. Localities generally conduct a request for proposals process with organizations that want to deliver new services or require existing providers to transition to an evidence-based model. In both cases, it is critical that programs operate as part of a coordinated system of early care for vulnerable families.

Baltimore leaders worked hard to have programs operate as a system by reducing individual program branding and competition for clients. They also worked to help providers focus on making progress on key outcomes—specifically, infant mortality.

To provide NFP, Baltimore built it from the ground up and housed it in the city Health Department. For HFA, the city helped existing home visiting providers transition to using the model. All programs are run by local community organizations.

Both approaches had challenges. Building and staffing a new program takes time and resources. Five years later, NFP is still not at full capacity, and HFA has struggled with retraining workers and staff turnover. Overall, however, Baltimore is moving in the right direction. Both models are above 85 percent of capacity in the city.

Communication between key partners was essential to Baltimore's transition, particularly to unifying the disparate components of the system. It kept people informed, provided an outlet for identifying and solving problems, and strengthened relationships. To facilitate that communication, BHB created Babystat, a coalition of organizations and agencies that support home visiting programs in Baltimore. Babystat provided an opportunity for stakeholders to come together monthly to discuss issues, make decisions, and share information. Among the issues that participants tackled were whether home visiting coverage was adequate in targeted communities, how to effectively allocate slots, ways to troubleshoot capacity issues, and what financial resources were available. With Babystat, "we can really talk about what our vision is, what our goals are, and keeping us on track with that," said one participating organization's deputy director. "Then, we're able to bring all of that back to the greater community."

Informal communication channels were also critical to success. Key players such as BHB; HealthCare Access Maryland, a nonprofit agency that manages the single entry point through which families can access Baltimore's home visiting system; the Health Department; Family League of Baltimore; program sites; and the evaluation team formed strong relationships and spoke regularly to get clarification on issues, answer questions, and discuss such topics as how the referral process was progressing and new ways to increase capacity and improve data collection. These informal communications not only kept partners informed but also strengthened connections among them.

Despite Baltimore's success in implementing evidence-based home visiting, the transition had its share of setbacks and pitfalls. Staff resistance and turnover and expanded data collection requirements from multiple agencies had to be managed. New eligibility standards often meant that home visiting participants had to be transitioned out of the program to make room for other women who met the latest criteria.

Finally, Baltimore leaders worked hard to have programs operate as a system by reducing individual program branding and competition for clients. They also worked to help providers focus on making progress on key outcomes—specifically, infant mortality.

One example has been a citywide campaign on safe sleep, which included special training for service providers, an intensive marketing campaign, and free cribs for vulnerable families. Every local hospital is required to show all new moms a video about safe sleep. The video is also played on a loop at Women, Infants, and Children sites; central booking areas of city jails; barbershops; laundromats; and through targeted social media outreach. This effort helps reach people who might not normally interact with the health system.

Step 5: Provide staff with training and technical assistance

Home visitors and their supervisors need to be adequately trained in the skills and methods they are being asked to add; given tangible links between the new method and expected outcomes; and provided with continuing support, coaching, and feedback. Ongoing involvement in training and forums can keep staff engaged and energized, even in the face of challenges. Ensuring that individuals are knowledgeable, capable, and motivated to implement new programs, and creating a work environment that fosters learning and collaboration, can make it easier to implement organizational change.⁶

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NFP home visitors are specially trained, registered public health nurses. Each nurse home visitor is allowed a maximum caseload of 25 mothers and must meet weekly with directors for clinical supervision. Home visitors and supervisors must, at a minimum, possess a bachelor's degree in nursing.

HFA staffing includes family assessment workers who perform initial assessments using HFA's Parent Survey, and family support workers who conduct home visits with enrolled families. HFA home visitors are highly trained, experienced paraprofessionals. Supervisors, who must at least have a bachelor's degree, monitor home visitors and their caseloads, which can fluctuate between 15 and 25 families depending on the severity of needs.

The national offices of both HFA and NFP provided initial training on their respective models and offered technical assistance during implementation, both on-site and via telecommunications, including email, telephone and conference calls, and webinars. These services provided Baltimore's home visitors with the structure and support they needed to move to the new, evidence-based models. "They were great trainers," recalled one program administrator. "They were just very interactive and really engaging, which is always good for learning."

The highly experienced HFA and NFP national staff was sensitive to the difficulties service providers face when confronted with this type of transition, and they offered counsel and support as well as technical training. Home visitors found representatives from both models to be particularly responsive during early implementation, when questions and issues about enrollment criteria and service components required quick feedback. "You could just send an email and get a quick response," said another local program administrator. "And you're getting a response from 'experts.' That just alleviates a lot of time and stress."

In addition to training and technical assistance from the model developers, home visitors also received support from local staff at DRUM, who had operated an HFA program in Baltimore for years. DRUM staff were able to mentor new HFA home visitors, passing along their firsthand experience and practical knowledge, such as how to use the required data collection forms. DRUM also allowed staff from other home visiting programs to shadow them on home visits to get a better sense of staff-client interactions.

Step 6: Establish a central triage and referral process

A central triage, or intake, and referral process is essential to ensuring that the most vulnerable families are served with the most intensive interventions and that more stable families receive an appropriate level of care. The process can help eliminate duplication of services and deliver the most targeted use of limited funds.

Creating a unified triage process was particularly important because both evidence-based models have enrollment criteria that the previous referral system could not address. For example, to be eligible for NFP services, women must be enrolled in the program before their 28th week of pregnancy.

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As previously mentioned, HealthCare Access Maryland (HCAM), a nonprofit agency that helps state residents enroll in publicly funded health insurance programs, managed a single point of entry for Baltimore's home visiting system. HCAM developed a central triage process to match women to home visiting services based on their risk profiles for poor birth outcomes, rather than ZIP code or census tract, as was the case in the old system.

The city hired a maternal health expert to develop a vulnerability index, which establishes a four-tier hierarchy of risk factors associated with poor birth outcomes. The triage process uses this index in concert with data from the Prenatal Risk Assessment (PRA), which is collected during the referral and enrollment process. This system makes it possible to identify the highest-risk women and refer them to the limited slots within the NFP program.

The new process begins as soon as HCAM receives a referral, which can come from various sources, including physicians (all of whom complete the PRA for women referred for services), hospitals, the Maryland Department of Health and Mental Hygiene, community service agencies, and women themselves. Within 48 hours, each referral is assigned to an HCAM staff member, who contacts the woman to gather additional risk data needed for the vulnerability index and share information about home visiting services. Information from the index, PRA, and this follow-up outreach is immediately integrated into a risk profile, and, if eligible, the woman is referred to an appropriate home visiting program.

Before Baltimore's transition, the city required programs to fill out PRAs, but they often did not comply. Now, enforcement is strict, adding integrity to the entire system and helping ensure that families are connected with the appropriate level of support.

Additionally, because there are multiple avenues for referral, women were often offered duplicative services under the old system, with more than one program trying to recruit the same family, while others with very high need were sometimes offered no services at all. Now, no matter how families are recruited, they must go through HCAM, so there is no duplication.

The number of pregnant women eligible for Medicaid in Baltimore far exceeds the number of home visiting slots available with current funding. So the city developed a central triage and referral protocol to ensure that the highest-risk women receive the most intensive services offered. Low-income, first-time moms who are less than 28 weeks pregnant are referred to NFP. Women who have high medical risk factors—such as previous preterm births, hypertension, etc.—are eligible for the enhanced HFA program; those with low medical or social risk factors to the traditional HFA programs. Two professors from the Johns Hopkins University’s Bloomberg School of Public Health, Darius Tandon and Bernard Guyer, were particularly instrumental in defining the triage criteria for the home visiting system.

Women who don’t qualify for home visiting are contacted by HCAM and offered a less-intensive program, Baby Basics—a clinic-based health literacy program that helps pregnant mothers read, understand, and act on health information—as well as center-based services. This ensures that all women in need are served in some capacity. Baby Basics is offered at various locations to all at-risk moms.

Step 7: Establish a monitoring and reporting system

Adopting new programs and services can put fresh demands on evaluation and monitoring mechanisms. Existing systems often are not adequate to meet new reporting requirements, but collecting data is essential to measure program implementation and quality, provide evidence of effectiveness, inform stakeholders, and influence funding decisions.

Baltimore established a standardized data-reporting format for all of the city’s evidence-based home visiting programs.

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The city Health Department already had methods in place for tracking indicator data and meeting NFP and HFA data requirements. It also had staff members who understood how to use them. As one program administrator said, “The planning phase, in terms of using data to guide us, was pretty easy. Especially here at [the Health Department] because we already had a pretty good database where we could extrapolate data. And we also had a relationship with the state where we were able to look at the state data. We had a great staff that’s used to crunching numbers and looking at the data.”



To help with the planning and transition phases, the city brought in Carson Research Consultants, a Baltimore firm with long-standing relationships with many of the key stakeholders, to help reconcile federal, state, local, and program data requirements and develop a uniform entry and reporting process. Carson is also conducting ongoing program evaluations.

Because the new evidence-based home visiting system is funded in part with federal MIECHV dollars, programs must collect and submit data on specific indicators. In addition, the state, which administers federal home visiting funding, has its own requirements. Stakeholders at the local level also need certain information collected to assess progress and make improvements.

These data requirements were not always consistent, and they changed frequently. In addition, stakeholders often disagreed about how best to collect the data. For example, although maternal depression was an indicator of interest to everyone, there was no agreement on which assessment tool to use for gathering that information.

Carson was able to make progress on developing a common set of indicators. When agreement could not be reached, it designed an “indicator grid” that lays out the various data requirements for each of the four stakeholder groups (federal, state, local, and program) and shows overlap, duplication, and inconsistency among the various requirements. The grid is the “go to” document for BHB and home visiting staff to manage data requirements.

The research consultants also collect data across home visiting programs on an ongoing basis and report on it at citywide meetings. These data are being used to assess program effectiveness and identify what is and is not working in the new system. In addition, Carson is involved in ongoing efforts to streamline data collection and build evaluation capacity within individual home visiting programs, including identifying ways to use data for monitoring and improvement.

Step 8: Monitor implementation and outcomes

All of the steps outlined to this point give states and localities the best chance to create strong outcomes with families participating in home visiting services. However, monitoring program implementation and measuring the results with real data are the only true ways to know if desired outcomes are being achieved.

All of the steps outlined to this point give states and localities the best chance to create strong outcomes with families participating in home visiting services. However, monitoring program implementation and measuring the results with real data are the only true ways to know if desired outcomes are being achieved.

Baltimore's efforts to improve the performance of its home visiting system have been going on for several years, but it is still too early to definitively determine what is being achieved. Recent data show a reduction in infant mortality, but those gains cannot conclusively be linked to home visiting efforts.

Most programs are only now reaching full caseload capacity under the new models, and few have families that have completed the evidence-based curricula. Outcomes will become clearer over the next several years. In addition, other goals the city is pursuing, such as school readiness, can be tracked only longitudinally, once participating children are 4 or 5 years old.

Despite these limitations, unlike five years ago, Baltimore can be sure it offers coordinated, evidence-based home visiting services.

The city is measuring how participating families are faring on a number of key child and family health and education indicators:

- Prenatal, postpartum, and well child visits.
- Breastfeeding.
- Tobacco use.
- Emergency room visits for children and mothers.
- Increased support for child learning and development.
- Improved parenting behavior and parent-child relationship.
- Reduced child maltreatment and domestic violence.
- Increased yearly income and educational attainment.

With this information, Baltimore will be able to quantify the results of its home visiting efforts and make adjustments to programs that are not performing as intended. This work has the city on track to clearly help vulnerable families become healthier, more successful, and self-sufficient.

Baltimore's Home Visiting Transition at a Glance

In 2010, Baltimore began its transition to evidence-based home visiting services using two models that meet criteria established by the U.S. Department of Health and Human Services—Healthy Families America (HFA) and Nurse Family Partnership (NFP). These models are being implemented in the city with support from Family League of Baltimore and the Baltimore City Health Department.

Pre-transition system

Capacity: In 2009, before the transition to evidence-based home visiting, Baltimore had the capacity to serve 1,722 families through nine home visiting programs. (See Table 1.) Of those programs, only one, DRU/Mondawmin (DRUM), was implementing an evidence-based model (Healthy Families America). DRUM had 170 to 200 slots, depending on the level of client needs.

Table 1

Previous Landscape of Home Visiting in Baltimore

Home visiting programs	Capacity
M. Peter Moser Community Initiative at Sinai Hospital of Baltimore Inc.	75 slots
The Family Tree	50 slots
Bon Secours Health System	55 slots
People's Community Health Center	72 slots
Healthy Start II—Greenmount	100 slots
DRU/Mondawmin Healthy Families	170 slots
Healthy Start Historic East Baltimore	350 slots
Healthy Start West Baltimore	350 slots
Maternal & Infant Care Program (Baltimore City Health Department)	500 slots
Total	1,722 slots

Source: Baltimore City Health Department

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Post-transition evidence-based system

Capacity: In combination, HFA and NFP can serve 800 Baltimore families at any given time. HFA will cover approximately 86 percent of that total, with NFP serving the remainder. In addition, Early Head Start began offering 300 additional slots in 2013, bringing the total to 2,100.

Table 2

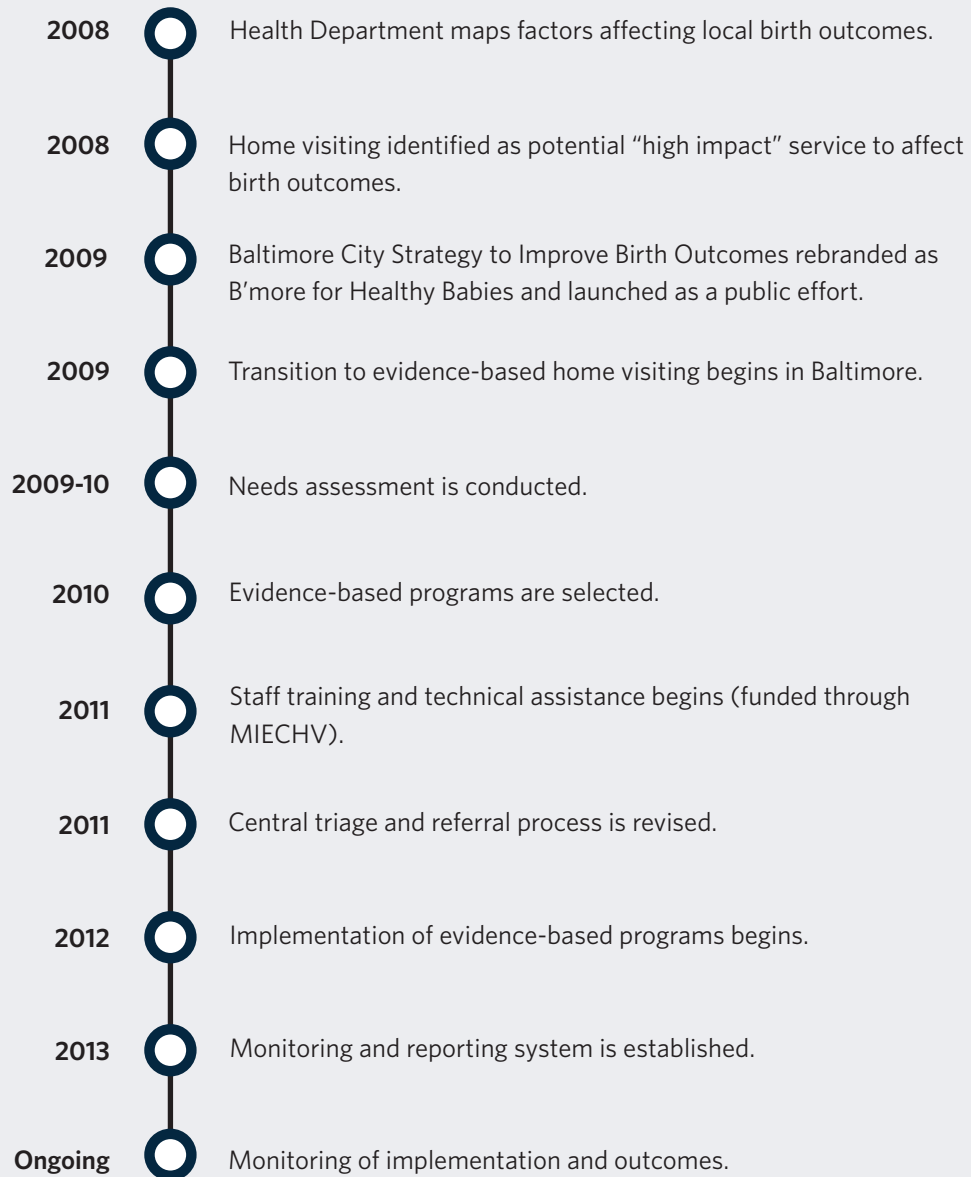
Present Landscape of Home Visiting in Baltimore

Home visiting programs	Capacity
Nurse Family Partnership	100 slots
HFA—Enhanced Mother and Infant	150 slots
HFA Traditional	550 slots
Early Head Start	300 slots
Federal Healthy Start	1,000 slots
Total	2,100 slots

Source: Baltimore City Health Department

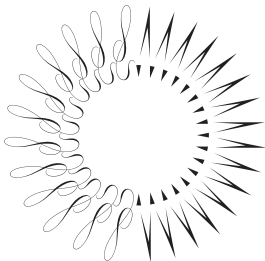
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Baltimore Transition Milestones



Endnotes

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